Nonverbal Treatment of Neurosis

Techniques for General Practice

CHARLES T. BATTEN, M.D., Los Angeles

• "Psychosomatic medicine" does not demand that the general practitioner function as a psychiatrist; rather, it is a psychiatric orientation that can increase the effectiveness of purely medical treatment for such conditions as neuroses. The general practitioner to whom the patient turns may achieve permanent results with nonverbal techniques where formal psychotherapy would be impracticable or unacceptable.

The first aim is to relieve pressure so that the patient can regain his mental balance and thereby his self-confidence. Arts, hobbies, sports, and the like can be prescribed rather specifically according to the patient's personality and needs. Nutrition can be improved simply at first by prescribing needed additions to diet rather than imposing restrictions. Vitamin deficiency may by itself be the cause of neurosis or more serious mental disease, whereas psychic stress by itself may create a need for additional vitamin intake. Hormone therapy may be extremely helpful but must be based on clear indication and limited to specific purposes.

Since lack of sleep and rest quickly impairs mental function, it is important for neurotic persons to learn relaxation as a necessity for sleep. Sedatives may be used in a crisis but should be abandoned as soon as possible.

With all drugs there are problems of excess and habituation. The least, the mildest, the shortest dosage is the ideal.

The initial steps of psychotherapy are available to any physician: Establishing rapport, noting how complaints are stated, encouraging ventilation, winning confidence rather than immediate results.

HOWEVER SINCERELY the general practitioner may acknowledge the concept of psychosomatic medicine and the inadequacy of purely physical treatment for disease, he cannot be expected to function as a part-time psychiatrist in addition to his other duties. What is he to do, though, about mild neuroses that are not serious enough to require psychiatric referral or even consultation, but for which sympathetic listening and common-sense advice are not effective? Is he to be content with placebos and topical treatment while mutual discouragement overcomes him and his patient?

This problem cannot be solved by insisting that the general practitioner is the counterpart of the old family physician. The social and economic conditions which were the basis of that close relationship cannot be reconstructed at will and therefore the comparison has at best a sentimental value. But he is the physician who has been consulted, and he can offer help which might not be accepted as readily from a psychiatrist.

Fortunately, a number of techniques have been evolved which may be effectively applied in such borderline cases. These "nonverbal techniques," as they are here termed, may substitute temporarily or permanently for the primarily verbal method of the psychiatrist. Some of them are ancient, some have developed in the same period as modern psychiatry; but all have been overshadowed until recently by the psychoanalytic method and some have almost fallen into disrepute. Now the tide has turned. Nonverbal techniques have assumed a much more important place in the psychiatrist's management of the neuroses, and the general practitioner as well can use them safely.

A twofold change has taken place with regard to what was formerly known as "physical methods" in psychiatry. Chemotherapy and substitutional therapy have been added to the old techniques like insulin and electric shock, lobotomy and leukotomy. These newer methods do not require hospitalization, can easily be combined with any kind of topical treatment, and are particularly indicated in neurotic disturbances; formerly held in lower esteem as mechanistic and merely symptomatic, they are now accorded full status. Meanwhile, better understanding has been gained regarding the role of the patient in working out his own problems and thereby acquiring a working degree of mental health. This process in the patient has assumed increasingly greater importance,[60] and anything which might help it can now be regarded as contributing to the final result. "The actual therapeutic potential is to be found and elicited in the patient, not applied by the psychotherapist."[51] Measures formerly used only to quiet the patient or to keep him occupied (occupational therapy) are now prescribed with a different aim—to help him over a crisis, this furthering his own efforts toward integration: "The patient,"

Associate Professor of Psychiatry, College of Medical Evangelists, Los Angeles.

Submitted August 2, 1958.

Taylor[48] explains, "is guided either directly or indirectly to realize how much he can do for himself rather than being made to feel how much the therapist is doing for him." Prescribed activity can become "the affirmative manifestation of an otherwise maladjusted nature." Sedation is seen in the same light. The physician's function, says Alexander,[2] is to remove obstacles and thus "create conditions in which the regenerative powers can best act . . . Once an obstacle is removed, the rest of the therapeutic task can be entrusted to the ego. War experiences have shown that in many traumatic neuroses simple sedation may suffice. This allays anxiety that temporarily interfered with the ego's integrative faculty. One is inclined to assume that in procedures like narcosynthesis the major therapeutic effect is the relief of anxiety . . . which temporarily hampered the ego's integrative capacity." Thus sedation is employed with a psychotherapeutic intent. The same applies to all nonverbal techniques in the treatment of the neuroses: Each might be prescribed for merely temporizing or supportive purposes, but by the psychotherapeutic intent they become important means of psychosomatic management available to the general practitioner.

Recreation

Nonverbal techniques of therapy were first applied in the treatment the child, who in "therapeutic play . . . may discharge his feelings without fear of being censured or punished. Such a secure emotional discharge serves to quickly reduce the child's anxiety, enabling him to move safely on to therapeutic experiences."[23] The adult equivalent of children's play—leisure activity—may be used in the management of the neurotic patient, both to amuse him and to promote his readjustment through "the psychodynamics of the highly motivated play situation."[9] The overriding consideration must be to propose constructive use of leisure hours, weekends and vacations, which for poorly organized persons may be emotionally upsetting and initiate regressive behavior.[28]

To this end, the physician himself must be familiar with the wide range of therapeutic and supportive measures. To mention a few: Bibliotherapy has been described as a means of psychotherapy through reading. Patients with some insight into their problems may profit from semi-popular books dealing with mental health,[13,16] but novels, poems or plays likewise may divert the patient and at the same time introduce new ideas and suggest purposeful goals. Music[25] and graphic arts, too, may awaken the patient's creative resources. A group setting is frequently preferable to single instruction or work, and the emphasis should be not on technical proficiency but on releasing suppressed emotions and unexpended energy, and on opening up new fields of interest. It is precisely for this reason that, for a professional artist whose real or neurotic problems arise from his work, art therapy may even be detrimental. For the same reason, less pretentious art forms—Moreno's psychodrama,[59] folk dancing, handicraft and the like—may be more beneficial than the fine arts with their professional orientation. Whatever the hobby, it should be selected on the basis of the patient's life setting, traits and complaint. For instance, it would certainly be wrong to recommend stamp collecting for a person of compulsive tendencies. On the other hand, chess, although a silent and lonely game affording only a minimum of interpersonal relationship, might be for some patients a means of working out deep-seated problems.[27]

Nutrition

More conventional supportive measures, such as are used in many purely medical situations, may be applied to the neurotic patient with the same psychotherapeutic emphasis. The difference not only lies in a changed physician-patient relationship, but extends to follow-up and duration of the prescribed regimen. In treating a medical disorder by diet or by vitamin or hormone supplementation, it is not necessary to prolong the follow-up much beyond the subsidence of acute signs and symptoms; but in the psychotherapeutic situation these improvements must be presented as a new way of life that must be pursued regularly for sustained effect.

The main difficulty with diet is not to determine the best regimen but to select one acceptable to the patient. It may be best to begin with only a few needed additions to his habitual diet. In the minds of many people diet has become a bugaboo, an additional source of frustration, a punitive device denying one of the few reliable remaining means of gratification.[1,33] The strategic approach is to be satisfied initially with slight but effective adjustments in the patient's nutritional pattern. Once confidence is established he will more readily accept further changes until a regimen is worked out on the underlying principle well formulated by Sargant and Slater: Sufficient quantities of a well-balanced diet rather than large amounts of an ill-balanced intake.[41] The transition to a fully adequate diet thus becomes part of an overall learning process.

Vitamin supplementation should be seriously considered for any psychosomatic or neurotic complaint; it is well known that the classical deficiency diseases often are accompanied by mental symptoms.[42] Pellagra, for example, leads in many cases to overt neurasthenia, but many neurasthenic symptoms may occur as the only evidence of vitamin B_1 deficiency, as also in the prepellagrous stages of B_2

deficiency—insomnia, anorexia, palpitation, headache and irritability. The night blindness of vitamin A deficiency often occurs on a hysterical basis. The clinical picture in other vitamin deficiencies is less clearly delineated, but in general when one vitamin is lacking the supply of all others can be presumed to be correspondingly low.

Physicians are at present in the skeptical stage of their experience with vitamins, but better understanding of nutritional factors[21] and more refined methods of experimentation and observation[15] have made it possible to demonstrate convincingly the usefulness of vitamin supplementation in the management of the neuroses. It is recognized, first, that the vitamin content of the ordinary diet is too unreliable to support the stress of psychosomatic disease, and second, that supplementation of one vitamin may even accentuate rather than relieve symptoms. Usually, continuous supplementation is necessary for a long time before vitamin metabolic balance is restored and normal tissue demands consistently met. Like diet, vitamin supplementation should become part of the patient's way of life, to be continued almost indefinitely. In general, any multiple-vitamin preparation, preferably including minerals and other nutrients, may be prescribed in doses sufficient for established minimum requirements. Such therapy has by itself dissipated pronounced neurotic symptoms,[50] and in combination with drug therapy has been found highly effective in a clinical setting comparable to a private office.[12]

Hormone Therapy

Hormone therapy in psychiatry, Sargant and Slater[43] concede, "is rather the hope of the future than the practical measure of today." It should be restricted to recognized indications in demonstrable deficiencies and never abused as a cure-all. Desiccated thyroid, in doses of one or two grains a day, counteracts mild depresion. Confusion, lethargy and inability to concentrate may be the result of myxedema[5] and disappear on administration of thyroid; but it must be remembered that prolonged intake of the hormone can lead to thyroid atrophy. Estrogen, possibly combined with progesterone or testosterone, may be tried in menopausal symptoms as well as in premenstrual tension. In some women, though, estrogens aggravate depression and should not be given over a long period without a thorough endocrinologic evaluation. Most healthy women can sustain the stress of hormone fluctuation, and prolonged or severe symptoms indicate more basic problems.

Rest and Activity

One of the most critical deficiencies is lack of rest and of sleep, in which "the activity of the self-system can be abandoned for a certain part of the twenty-four hours."[47] Lacking this relief, a person's ability to handle unwelcome, disapproved motivations, anxieties, etc., deteriorates rapidly with consequent impairment of mental health.[46] According to Pavlov[32] "sleep is inhibition spreading over all the hemispheres"; this quite generally explains the restorative power of rest, sedation and sleep.[57] These are not the same as the sleeplike conditions of anesthesia and hypnosis[14] and in all probability sleep induced by hypnotic drugs is in this latter category, overpowering somatic tension rather than releasing it.

It is by now well understood that wakefulness is due to anxiety or, more generally, to overactive ego defenses. The aim is to by-pass these defenses in order to alleviate the causative anxiety or other neurotic tendency through the curative effect of healthy sleep. Physiologically, sleep is a state of functional de-afferentation[18]; in particular the feedback from muscular impulses must have come to rest before the patient can follow the diurnal rhythm from wakefulness to sleep. This may be achieved by relaxation of the body in a tepid bath (as the ancient Greeks recognized[26]), by a better planning of the day's activities to permit rest periods, and by a slowing down of pace toward bedtime. One person may be quieted by an evening walk, another by reading, others by prayer[49]; but in any case, "sleep must be wooed and is not to be captured in one swoop."[31] As Kleitman reminds us, sleep is at least partly a learned process.[19] Medication is only used to bridge the first critical period of insomnia or broken sleep; it should be of the mildest effective kind and withdrawn as soon as practicable. Myerson[30] made the excellent suggestion that it should be taken an hour or two before retiring so that by the time the patient gets to bed he is really ready for sleep. Toilet preparations should be completed shortly after the evening meal; thus the patient, instead of relying on drugs, is learning habits conducive to a good night's rest.

Necessary as ample sleep and rest are for the neurotic patient, the management should never become overprotective. Whitehorn[52] cautioned that stress has become a "bad word"' and that we fail to recognize how much mental illness is attributable not to stress but to the lack of it or, in his own words, to "the personal experience of uselessness and a collapse of meaningful effort." A truly productive plan of reeducation should lead to "the organization of life toward energetic effort in stressful situations rather than the avoidance of stress." For some persons, work (for example, gardening, carpentering, mechanics) may be as health-giving as rest is to others. It is interplay between rest and effort that makes for stability through adjustment.

Drug Therapy

The ancient sedatives and stimulants—alcohol, opium, hashish, tobacco, caffeine—have been vastly supplemented in recent years, but the underlying problems of excess and habituation remain the same. We must ask ourselves whether more than temporary relief of neurotic symptoms is ever achieved by these methods, and whether even this result is not too high a price to pay in view of the dangers. Even the tranquilizers have recently been listed as habit-forming drugs by the World Health Organization.[56] The theme of this presentation applies to drugs also: They may serve to help the patient over a crisis from which he can proceed on his own powers. Always, the drug must be (1) selected with regard to the history and symptoms; (2) the mildest agent in the lowest effective dosage; (3) followed up and withdrawn at the first sign of ill effect or when no longer required.

Tranquilizers tend to reduce anxiety, nervous and muscular tension and acuity of awareness; they are mildly depressant, but not as powerful in their action as central depressants like the bromides or barbitals.[22] The best current opinion seems to be that chlorpromazine and reserpine are very useful in the treatment of patients in hospitals, but they are much less promising for ambulatory neurotic subjects. Anyway, their effect is not clearly predictable. For example, chlorpromazine seems to be beneficial in most patients with acute anxiety neuroses, while in others anxiety and related symptoms are decidedly increased.[39] The drug seems to do best in neurosis of the obsessive-compulsive type; in depressive states it is ineffective and may even aggravate the complaint.[24] Reserpine usually relieves neurotic symptoms within a matter of hours, but it is likely to break down protective defenses and release underlying drives in a display of emotions which may be disturbing to the patient and difficult for the physician to handle.[20] Most important, both chlorpromazine and reserpine as well as meprobamate (Equanil,® Miltown®) are beset by a considerable number of untoward side-effects, among which may be mentioned leukopenia, impairment of liver function, urinary retention, purpura, diarrhea and hypotension.[58] In this context the results of a carefully controlled British study are very enlightening.[35] Various tranquilizers ("Nutinal," chlorpromazine, meprobamate, and "Sedaltine") were tested against amobarbital (Amytal) and a placebo; while there was no difference in the potency of the four tranquilizers, only the barbiturate proved significantly more effective than the placebo. Some observers may go as far as to conclude that "in general the tranquilizers appear to have little or no advantage over placebos in the treatment of neurotic outpatients."[10] At any rate, although amobarbital and the other barbiturates are not without hazards of their own, physicians are at least aware of the risks involved and familiar with indications and dosage, whereas even the widely used tranquilizers have not yet been sufficiently tested for anyone to be sure of all their effects.

Stimulants like benzedrine, dextro-amphetamine and others are helpful in the management of slight depressions but cannot control the more severe forms. The effect, furthermore, is short-lived. Sargant and Slater[40] suggested that benzedrine may afford the depressed patient a day or two of comparative normality and that this experience can be used to impress upon him that his illness is not as hopeless as he thought. When anxiety is the predominant symptom, though, stimulants will only aggravate the condition. Myerson[30] observed that a combination of amphetamine derivatives with one of the barbiturates helps to reestablish an approximately normal emotional state, thus bringing the latent forces of the organism for cure or remission into play. Ferguson[12] employed a stimulant (methylphenidate hydrochloride) to counteract the effect of psychosedatives and neurosedatives as well as the patient's initial underactivity, and thereby was able to produce a state of "active tranquility."

The earlier expectations that the ataractic drugs, in addition to exerting a sedative effect, will also increase ego strength do not seem to have been fulfilled as yet.[6] The old barbiturates and bromides, far from being merely "chemical restraints," still remain very useful tools in the management of neurotic crises. Placebos, on the other hand, hardly deserve a place in the treatment of psychosomatic disease. It has been recognized that every drug in addition to its pharmacological effect also exerts a psychological and sociological influence, the latter being due to the "milieu effect."[30] Furthermore, the action of placebos is not entirely imaginary, for measurable physiologic changes at the end organs have been demonstrated.[55] Yet it would seem that in the management of the neuroses the use of placebos introduces an element of deceit which clashes with a basic concept of psychotherapy, that is, the establishment of a relationship of confidence between physician and patient in order to promote healthy reactions in the disturbed subject.

DISCUSSION

The foregoing discussion of nonverbal techniques, although far from complete, may suggest the wide variety of modalities available, their applicability depending on the patient's personality, his resources and the preference of the physician. There is a personal style in nonverbal psychotherapy, as in more formal methods, and the physician can best use the means he understands and relies on. Indeed, all

psychotherapy has important elemental and nonverbal aspects,[3] relating back to the early, nonverbal events with which psychopathology is so much concerned. "The patient has to gain communicative experience in the nonverbal mode before he can engage in verbal exchange,"[37] and communication "motivated by love in the widest sense of the word including the religious, and guided by understanding . . . is capable of producing profound psychic and physiologic effects."[4] This element, moreover, may prove to be the basic ingredient in the management of neuroses, for which the rate of success appears to be similar whatever modalities have been employed. Bowman and Rose,[7] reviewing 11 reports by different investigators over a 20-year period, found the range of improvement from 55 to 87 per cent with an average of 67 per cent. Miles and coworkers[29] arrived at a mean average of 73 per cent, while Schjelderup,[44] in a smaller series, obtained lasting improvement in better than 87 per cent with psychoanalytic treatment alone. Eysenck's tabulation,[11] although widely criticized, suggests at least worthwhile improvement from treatment by custodial institutions and general practitioners (72 per cent) compared with success of psychoanalysis (66 per cent) and eclectic treatment (64 per cent).

As Braceland[8] observed, "We now may regard it as axiomatic that no one approach to psychiatric disorder can claim a monopoly upon wisdom, understanding or therapeutic efficiency." Redlich[36] noted that most psychodynamic therapy is applied to patients of the upper and middle classes, while psychoneurotic persons of lower class are most likely to receive only supportive and manipulative psychotherapy. He ascribed the difference not only to economic reasons but also to difficulties in communication between the middle-class psychiatrist and the lower-class patient. The general practitioner, more accustomed to dealing with patients of all classes, may be better able to bridge the gap both verbally and nonverbally.

Certain psychiatric techniques may be helpful in guiding the physician to a selection of therapeutic methods. The history, first, should be taken in an unhurried manner. The patient who is always under some strain is thus given a chance to relax. This does not mean that the permissive approach is necessarily in all instances the best; sometimes firmness is much more effective, but the physician's basic attitude should be open and truly compassionate, never moralistic or prejudging. What is required is to establish rapport. Only if the patient feels that he can trust the physician will he open up and talk freely, thereby giving the therapist an opportunity to collect the facts and size up the situation. Rapport has been described as a necessary nonspecific factor in any psychotherapeutic procedure,[61] and the same holds true with regard to ventilation: The patient is encouraged to tell his story, thereby unburdening himself of his troubles. Such an emotional release is sometimes all that is required, but in other instances it will at least indicate his readiness to accept constructive measures and suggestions. However, a word of caution may be in order—"not to remove the lid from the boiling cauldron of the patient's emotions unless it can be got back again."[53]

What makes of routine history-taking a preliminary psychotherapeutic interview is the added attention given to every seemingly unimportant detail. It is important not only *what* symptom the patient complains about, but *how* he does it. Simple questions as to age, family status, occupation, general health and former diseases often bring forth answers which reveal the degree of adjustment to essential life situations. From all these data together with the patient's general appearance and manner the physician may form an impression of his personality and the seriousness of his condition—most important, his accessibility and his insight into his problems. On these findings the physician will decide how best to manage the case or whether a psychiatric consultation might be indicated.

Not only at the time of the first consultation but throughout the treatment by nonverbal means, the physician can find occasion for verbal contact with the patient. In fact, one of the greatest advantages of these nonverbal methods is that it becomes possible to weave psychotherapy unobtrusively into other consciously acceptable treatment methods, thereby enlarging the range of communication. Many a patient who cannot be reached by the verbal approach will be helped by such nonspecific therapy.

As in every other kind of psychotherapy, the immediate aim is relief of symptoms, and only time can tell what further benefits will accrue to the patient. Results will differ, of course. In some cases the subject will again be able to function on his former level, whatever that level might have been; in others there will slowly emerge a greater ability to cope with life's problems, a change for the better which the subject enjoys without fully understanding what has happened; or again, improved surface adjustment might lead to greater insight, more conscious re-learning, and resolution of deep-seated conflicts. Psychiatry has come to be much more realistic in its therapeutic goals and not to expect a complete remaking of every patient.[17] Thus, whatever the response may be, the general physician can make an important contribution by helping the patient to use his own recuperative powers for a fresh start toward better mental health.

The list of references is available from the author.

1720 New Jersey Street, Los Angeles 33.